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Organizational Ethics in Healthcare

Toward a Model for

Ethical Decision-making by

Provider Organizations

Institute for Ethics

National Working Group

Report

Organizational Ethics in Health Care: Toward a Model for Ethical Decision Making by Provider Organizations

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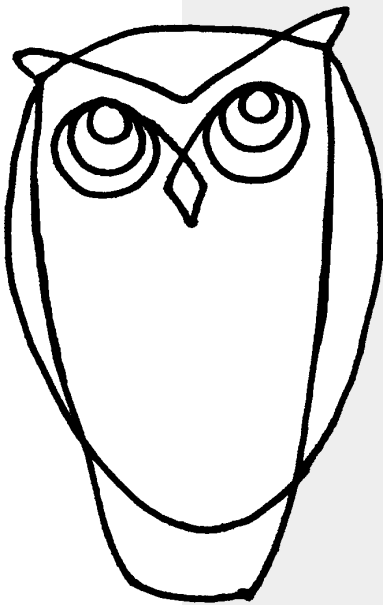
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Introduction

A concern with ethics in health care organizations is not something new. Most health care organizations strive to act ethically as they weigh the interests of the organization and of its many stakeholders. But the recent changes in the delivery of health care have brought increased public attention to health care organizations and make a careful examination of organizational ethics for health care provider organizations more urgent. Although the accountability of individual health care professionals has been extensively studied, the accountability of health care organizations has not received much attention. Therefore, the Institute for Ethics at the American Medical Association convened the Working Group and asked them to try to determine where the ethical insights of the relevant arenas of both practice and scholarship could be brought together.

The first aim of this essay, the focus of Part I, is to examine several systems of ethical reflection that can help in determining what should count as ethical conduct for the present generation of health care organizations. The authors' second goal is to outline a model for ethical decision making for provider organizations that draws guidance from the perspectives of business ethics, professional ethics, and contemporary law and social policy. However, the differences are so significant between these perspectives that trying merely to combine them does not yield a useful model of ethical decision making for real-world health care organizations. Therefore, part of the challenge we undertake in Part II is to elaborate on those standards we find ambivalent or inadequate to meet present and future societal and individual health care needs.

This paper focuses on organizations that provide health care to individual patients. Organizations in health care that do not provide direct patient care include insurance companies and some managed care organizations, as well as many federal and state government agencies, producers and distributors of health care goods, and the associations of health care professionals. Although these organizations are also held to ethical standards, this essay focuses on organizations of the first type, the provider organizations. Part III offers a fictional illustration of organizational decision making by a health care provider organization, a process that is guided by the standards we develop in Part II. In our conclusion, we reflect on some implications of this discussion and sketch the kinds of conversations that should take place if understanding of health care organizational ethics is to advance.

I. Sources of Organizational Ethics for Provider Organizations

Organizations and other collective entities are different from the individual adult human beings whom we routinely hold responsible for their actions and whose actions we judge ethical and unethical. There is a serious philosophical question whether organizations can be held accountable for their actions (Simon, 1965; Ladd, 1970). Arguments that this is possible are based on attributions of responsibility where both an identifiable decision-making process and a sufficient measure of coordination among the efforts of the individual persons who constitute the organization exist. These characteristics certainly exist in formal organizations that have explicitly delineated roles, offices, and decision-making structures. This essay accepts the position that health care provider organizations are rightly held to be ethically accountable for their actions (Werhane, 1985; Wolf, 1994; Scott, 1998; Spencer, et al, 2000; Werhane, 2000; Emanuel, 2000) and focuses its attention on the question of identifying proper criteria on which to base such judgments. Below we examine three areas from which to draw guidance—business ethics, professional ethics, and law and social context.

A. Business Ethics

Business ethics is primarily concerned with the decision making of organizations and managers. Efforts to identify the best practices of actual business organizations seek to formulate an appropriate normative conceptual framework for discussing the ethics of organizations. Early work in business ethics that emphasized the fiduciary obligations of managers and organizations to the stockholders has given way in the literature to stakeholder theory, although practice patterns still may not reflect this shift. The sections below address managerial ethics, best practices, and stakeholder theory in greater detail.

1. Managerial Ethics

Managerial ethics is important because an organization acts through the actions of its managers and representing officers. Managerial ethics attends to the decision making and character traits of these individuals. However, ethical analyses of managerial decision making are typically commodity-neutral. The standards of ethical managing are assumed to be essentially the same from organization to organization, regardless of the nature of the activity. However, we, along with others, claim that health care is viewed in American society as a special kind of good that cannot be dealt with ethically in the same way as most other commodities in the marketplace. Some scholars have formulated normative accounts of the ethics of health care managers that are not commodity-neutral and do try to take ethical account of the distinctiveness of health care (O'Toole, 1994; Wolf, 1994; Darr, 1997; ACHE Code of Ethics, 1999; Emanuel, 2000).

For example, the American College of Healthcare Executives (ACHE) has set out professional standards for health care managers and executives. Emulating commitments articulated by the health care professions, the Code of Ethics for the ACHE states that “the fundamental objectives of the healthcare management profession are to enhance the overall quality of life, dignity and well-being of every individual needing healthcare services; and to create a more equitable, accessible, effective and efficient healthcare system” (ACHE, 1999). Whether the ACHE will be successful in establishing health care management as a profession remains to be seen. However, this is a fresh approach to management that challenges the notion that management decision making is commodity-neutral and focuses attention on the particular mission of providing health care.

More attention to these themes is necessary, and future analyses will benefit from detailed work in health care organizational ethics. Individual decision makers’ ability to influence the actions of an organization is circumscribed by the structure of roles and offices, by the system of goals and priorities of the organization, and by its recent history and culture. Consequently, what should be added to managerial ethics is a focus on the structures for decision making and the goals of the organization. Special attention also must be paid to management structures in organizations that employ professionals (Raelin, 1986; Bayles, 1989). Medical professional culture is more collegial than executive and responds better to a matrixed or bilateral accountability system (Raelin, 1986; Emanuel and Emanuel, 1996; Emanuel, 2000). Application of general styles of management to health care professionals often results in demoralized and frustrated professional staff (Hughes, 1988; Parsons, 1954) and negative relations between health care professionals and health care executives (Relman, 1994).

2. *Organizational Ethics*

a. Best Practices

During the course of the last decade, some corporations have established ethics offices and/or appointed a senior officer to oversee ethics education and to establish structures that attend explicitly to the ethical issues that arise in the corporation’s daily life. The cynical view of this activity is that such initiatives are a veneer, just enough of what is now called a corporate compliance program to satisfy a judge, if the corporation should happen to be sentenced under the Federal Sentencing Guidelines (US Sentencing Commission, 1991). But some corporations are evidencing genuine commitment to these issues. One reason for this is that taking ethics seriously can make for a better corporation, no matter what measure of corporate performance is used (Weaver and Treviño, 1999; Beil, 1999; Ryan, 1999).

For example, one study of corporate best practice in non-health care settings set out to identify the characteristics of “visionary companies” (as identified by polling chief executive officers of 700 major corporations) that

correlated with their enduring prosperity and success (Collins & Porras, 1997). The patterns of difference dispel the myth that the most successful companies are those whose primary goal is profit maximization or increasing shareholder wealth. What is crucial is that a visionary company is driven by an ideology that “it lives, breathes, and expresses in all it does. . . . A visionary company almost religiously preserves its core ideology—changing it seldom, if ever” (p. 8). Visionary companies “seek profits, but they’re equally guided by a core ideology—core values and a sense of purpose beyond making money. Yet, paradoxically, visionary companies tend to make more money than the more purely profit-driven comparison companies” (p. 8).

Best practice research offers no clear prescriptive about what sort of ideology an organization should have. The implication of Collins and Porras’ research, however, is that innovative health care provider organizations need to be driven by a core ideology—in this case, by definition, the provision of appropriate health care. However, this ideology does not mean indifference to fiscal matters, much less guarantee fiscal failure; indeed, it may be the source of long-term survival and success just as other core ideologies have been for non-health care visionary companies.

b. Stakeholder Theory

The questionable perception that corporations need only be interested in profits was perpetuated by Milton Friedman’s statement that “there is one and only one social responsibility of business—to use its resources and engage in activities designed to increase its profits. . . .” (Friedman, 1970, p. 126). In response to this edict, during the late 1970s and early 1980s, scholars of business ethics developed a variety of conceptual frameworks for understanding the ethics of business organizations. Social contract accounts of corporations and theories of the rights of employees, consumers, and other players in corporate life were proposed in an effort to conceptualize the obligations of business organizations (see, e.g., Donaldson, 1982; Werhane, 1985; Solomon, 1991). During the last decade or so, much of this work has begun to coalesce around a framework for conceptualizing the ethics of organizations called stakeholder theory. It is an approach to organizational ethics that explicitly takes into account the different kinds of relationships that a complex organization can have with all the parties, both individual and collective, with whom it deals.

The core thesis of stakeholder theory is the normative claim that the interests of all the parties involved in any transaction ought to be considered in determining how to act ethically. In order to determine how an organization ought to act in a particular situation, it is necessary first to identify each of the parties (individual and collective) with whom the organization interacts and what each party has at stake. Second, one must ask how the organization ought to act in relation to each party, and then how the organization’s several obligations to these parties ought to be ranked, both in general and in the

situation at hand. We refer to the first as the analytic step and the second as the normative step.

Health care provider organizations interact with a number of different groups of stakeholders, including patients and their families; health care professionals; other professional and nonprofessional employees; suppliers; regulators; insurers, risk-spreaders, and third-party payers; financial contributors; and the larger community. However, these general categories are broad and require further specification to help determine the particular interests involved. For example, the general category of individual patients receiving care and their families includes at least the following subcategories: patients needing intensive care; patients with less serious conditions; patients with chronic health conditions; patients receiving well care; hospice patients; patients receiving aftercare; and future patients. In addition, the families of these patients will have differing interests and so fall into different subcategories, depending, for instance, on whether the patient receiving care is fully, partially, or not at all capable of participating in treatment decisions. Similarly, the several kinds of health professionals and other health care providers who care for individual patients within a provider organization play differing roles in relation to these patients and to each other. Their interests in relation to the organization are therefore not identical and require careful analysis for the organization's obligations toward them to be identified in detail. The community at large is also related to a provider organization in several different ways, as are the sets and subsets of other stakeholders.

The key question in stakeholder theory is the normative one: Which, if any, of these stakeholders should be given priority when the interests of several stakeholders conflict? This question cannot be answered simply from a description of the various categories of the provider organization's stakeholders and their interests. The priority of the interests of some of an organization's stakeholders over others' is often made clear by an organization's mission and core ideology. In the case of provider organizations, this is the provision of health care. Claiming priority for one group of an organization's stakeholders over another requires the formulation of ethical standards to support such a claim. We have argued that the guidance offered by new works on management ethics, by best practices, and by stakeholder theory all support the priority of patients.

B. Professional Accountability

Because health care organizations are engaged in the provision of professional services, there are important lessons to be learned from the ethics of the health professions. The literature of professional ethics has, however, focused primarily on the conduct of the individual members of the professions attending to the needs of individuals. Less often are the responsibilities of collective actors on behalf of populations carefully considered. The question of this section is: What are the ethically significant points of similarity between the activities of organizations and of individual health providers that enable a general

prioritization for ethical decision making by provider organizations? To carry out this inquiry, brief descriptions are necessary of a profession, professional ethics, and professional organizations' accountability.

1. Professional Ethics¹

Every profession is characterized by a certain defined expertise that consists of a body of knowledge and skill in applying that knowledge to the practical benefit of others. Because of the time and effort required to acquire expertise, and also because learning to apply this body of knowledge dependably requires learning by observing and imitating other trained individuals, the expertise of a profession is largely exclusive to the members of that profession. Society therefore must depend on professionals for the services they provide, as well as on their ability to maintain high standards of practice.

Professionalism should function to protect moral vulnerabilities that cannot be safeguarded through either the government or the private sector (Camenisch, 1983; Bayles, 1989; Ozar, 1994, 1995; Chassin and Galvin, 1998; Wynia et al, 1999). Professionals are thus obliged to use their expertise in service to the community and to promote the underlying values of the particular profession (e.g., health care values). Ideally, patients and others need not be constantly wary, because the members of professions actually practice according to these commitments. The practices and discourse surrounding these beliefs constitute the institution of professionalism. It is the existence of this institution of professionalism that should render people generally secure that professional expertise will not be used to their detriment and that should lead young professionals to want to be accountable to the ethical practice standards of their profession.

2. Health Care Professionals

Every profession's ethic includes some measure of special commitment to, and thus a prioritizing of, the beneficiary of the profession's services over other concerns and commitments. The ethics of the health professions include a commitment to putting the patient ahead of the well-being of the professional in many matters and situations. In the case of the health professions, this translates into the prioritization of health care values over self-interests and other goals that might conflict with health care. This core aspect of the ethics of the health professions is sometimes summarized in the language of trust. That is, the ethics of professionals should allow patients to trust that health professionals make judgments with the patient's health chiefly in mind and therefore entrust their bodies and their lives and the communities' health to the professionals' care (Goold, 1999; Rhodes and Strain, 2000).

Clearly, health care professionals must support health. However, this does not mean that the determination of what constitutes health or health care is controlled solely by professionals. On the contrary, the professional obligation requires acceptance of the patient as the primary decision maker in matters of his or her health. This is

the ethical requirement of informed consent, which the prominence of the value of autonomy in American society renders a high priority. Attaining this requirement is complex, since patients are often hampered in their ability to give informed consent by their circumstances. For example, the patient involved in the treatment decision is usually experiencing physical or mental suffering. In addition to being hampered by illness, future patients or consumers can also be hampered by the difficulty of understanding the complex and rapidly changing health care system. Consequently, the ethics of the health professions stresses that health professionals must support the decision-making role of the patient. The application of this obligation as we shift from the individual sphere to that of the population (and to questions of public health) is an important topic for scholars in health professional ethics.

3. Organizational Accountability

The language of professional accountability can also be applied to organizations in their relations to patient populations. "Accountability entails the procedures and processes by which one party justifies and takes responsibility for its activities" (Emanuel and Emanuel, 1996, p. 229). For health care organizations this means they must identify the parties to whom the organization is accountable (in other words, the stakeholders) and the activities for which they may be held accountable (in other words, the interests of the various stakeholders on which actions by the organization can have impact). They then must determine what actions by their organization are obligated by these stakeholder interests and accountability relationships, and with what priority.

There are points of similarity between the practice of health professionals in relation to individual patients and the actions of provider organizations in relation to individual patients. Provider organizations, like the professionals they employ or work with, are held accountable to act in ways deserving of patients' trust; and to do so, clearly they must give appropriate priority in their actions to individual patients' decision making and health. However, as has been indicated, organizational decisions typically also focus, and realistically should focus, on patient populations.

In regard to patient populations, we can draw some guidance from the analogy with professional accountability in answering the normative question of stakeholder theory. Given the mission of health care organizations, the stakeholders with first priority in a health care institution must be the patients and therefore the patient populations that the organization cares for. Exactly how these groups are defined is complex, but their general priority comes from the idea that a health care organization can and should be held responsible for its primary purpose, namely, the delivery of health care services (Emanuel & Emanuel, 1996).

Other forms of guidance may also be drawn from the nature of professionalism. Health care services, in a

professional model, are provided on the understanding that professionalism serves in society to promote health values and care when a challenge to them occurs (Wynia, 1999). Given the scarcity of health care dollars in most organizations and the needs of at least 40 million uninsured people in the United States, it is not unrealistic to expect provider organizations, like health care professionals and the ACHE, to take an active role in shaping public policy and to be held accountable for their actions in this area. If health care organizations are accountable in these ways, it becomes clear that managers and business administrators, as well as those with public relations, political, and other functions in the organization, are also accountable in these ways. Not only those professionals who deliver direct patient care but also those who interact with the organization's other stakeholders must be held to standards that prioritize patient population health care. In this sense, every employee of a health care organization is held to standards that reflect health care priorities.

C. Law and Social Context

Health care is provided within a societal context. Thus, the extent and type of health care to be given priority in a particular society's institutions are set in a process of negotiations between professionals, those who need or see the need for health care, and those who represent other values. Law and social policy are important components of the discourse that determines the extent to which health priorities can rank ahead of other societal priorities.

1. Law

There is support for most, if not all, of health professional priorities to be found directly in statutory and case law, and indirectly from the ceding of many regulatory functions to health professionals. None seriously dispute that both statute and case law correctly support the obligations of provider organizations to meet general standards of business conduct such as upholding reasonable contractual commitments. To do otherwise would harm patient care. From this obligation, it follows that responsible business practice sets an outer framework within which prioritization of health values can operate. In other words, while financial gain cannot be the primary goal of a provider organization, an organization also may not ignore financial matters in ways that compromise the health of the patient populations it serves. The extent to which organizational solvency/survival can be counted an ethical priority is discussed more fully in Part II.

In addition to supporting the two general priorities identified in our discussion of professional ethics (patients' decision making and prioritization of health), there is a third general ethical priority for health care decision making found in social policy and law. This is the priority of professionals' expertise in clinical matters. The powerful authority accorded to professional expertise in many arenas of professional practice, but especially in health care, is so taken for granted in the context of individual

professionals' practice that it is easy to overlook it there. However, as soon as we look at how decisions about health care matters are made by legislators, the courts, and the executive branch of government, and at how decisions involving health care matters are made in every major social institution of our society, we observe that the expertise of health care professionals is called on regularly. Professional expertise is one of the important determining standards on all health care matters.

As has been indicated, the necessary corollary of professional expertise is professional accountability. Accountability of individual professionals to patient care is indisputable in civil, criminal, and administrative arms of the law. Accountability of organizations to populations has been less clear. Recently, as the impact of organizational policy on patient care has been better understood, the law has begun to recognize the liability of organizations with respect to direct patient care. How this will play out in terms of accountability for population care is unclear. In any case, it is likely that the evolution of law in this area will be rapid and that increasing guidance will emerge regarding the relative priorities of population and individual care.

2. Social Context

As a result of medical spending patterns and general distrust of government both by the population in general and by the medical profession, much of the provision of health care within our society has been left to the market. The dilemma for provider organizations is that market competition as a vehicle for cost regulation pushes the competitive financial imperative into conflict with the professional imperative just discussed. While the business ethics model of "best practices" would likely keep financial gain and cost control a second priority, social policy presently demands of provider organizations that cost regulation and short-term competition be primary concerns. Moreover, the relative scarcity of information on quality in health care drives competition primarily by price, which may further hinder the prioritization of maximizing health.

In the situation where the analogy with professional ethics demands a priority for patient care while the market model encourages competitive pricing, and in a situation in which it continues to be uncertain what the society means by "population care" or "community," provider organizations are left to function by whatever definitions they can devise. Some provider organizations have interpreted these sources of guidance in ways that have prompted them to define their patient populations to exclude the costly sick, and also to exclude any nonenrolled people. Notions of the community that an organization serves, in other words, have been defined in ways that encourage select membership. While a number of commentators have characterized managed care by the tension it appears to create between individual

patient care and population care, in fact this tension is not new. Managed care might be better characterized by the need of health care organizations to define populations that can shoulder the distributed risk of their sick in a way that is consistent with society's requirement that the organizations maintain financial security.

As a result of the use of market competition as a vehicle for cost containment in health care, society is beginning to realize that health care values have been undermined by this policy and that society is the worse for it. Expanding on Okin's statement that some things are too important to be trusted to the market (Okin, 1975), some have argued that health care is one of a few forms of human good that take moral priority over the rest and should not be entrusted to competitive market forces (Daniels, 1985; Fein, 1986; Walzer, 1983; Shue, 1996; Ozar, 1983). The political will recently has focused on patient rights and on the growing number of uninsured. First piecemeal legislation and then efforts to ensure a broad scope of patient rights have been major foci of the recent politics of health care. A change in the ethical directives of social policy to provider organizations may be emerging. The development of policies that allow appropriate financial compensation for care of the costly ill and create universal access may lead to the evolution of ethical directives that minimize the likelihood of pitting patients against populations, populations against populations, and care against competitive financial gain requirements.

At the present time, however, the law (to some extent) and social policy (to a great degree) have given ambivalent or even contradictory guidance to provider organizations. By encouraging market competition and organizational accountability for individual patients' care, instead of responsible cost containment across the entire population, priority has been tacitly given to enhancing the health of some, especially the well and wealthy, rather than meeting the health needs of all, including the sick and poor. In such a system, the patient and community stakeholders appear to be ranked lower in priority, and the investors, employees, suppliers, and insurers higher, in spite of the conflict of this ranking with the priority of health. In general, this trend has confused rather than clarified priorities among stakeholders and their interests (Buchanan, 1998).

II. A Model of Ethical Standards for Organizational Decision Making

The fruit of the preceding reflections is not a set of narrow rules or an algorithm to tell the leaders of provider organizations what courses of action to take in various situations. Priorities are several and can be conflicting. The stakeholders of provider organizations are numerous and the situations in which these organizations must act are diverse and complex. Health care decision makers would rightly give little credence to ethical directions of this sort. However, ranked priorities can be helpful for guiding ethical decision making by provider organizations.

Summarizing the main points of these sources of guidance in the order in which they arise in the text, it should be possible to generate a list of priorities. Managerial ethics offers the wisdom of using management approaches suited to the collegial traditions of accountability and commitment to the purpose of health care. Organizational ethics demonstrates from best practices analyses the importance of a constant and compelling mission that must be drawn from the purpose of health care in this case, as well as organizational structure that suits the mission. Stakeholder theory confirms that obligations are due to those with interests at stake, and that these obligations should be prioritized according to the mission. Professionalism prioritizes issues within the overall mission, we suggest, in the following order: patient care and support for decision making; population health; expertise based on trustworthy standards and self-regulation; accountability for delivering services; and advocacy within society for health values. Law supports not only the professional priorities (e.g., of informed consent), but the business requirements (e.g., contractual arrangements). It also supports a serious role for professional expertise in policy formulation. It demands professional accountability for trustworthy standards and has begun to extend this to organizational accountability as well. Social expectations, by contrast, offer confusing directions. On one count they prioritize quality care for all conditions, on another they urge cost control by market competition, and on yet another they demand nothing less than universal inclusion.

From this summary, it appears that all sources prioritize patient health care over other stakeholders, and most acknowledge the compelling if competing need to provide for health of populations whether in public health policy or in patient population management. Expertise has an acknowledged place in these activities. Professionalism and social expectations prioritize attention to unmet health care needs and advocacy for reform if needed. Business ethics and professionalism as well as law and social policy prioritize management practices suited to collegial standard setting and mutual accountability. All sources acknowledge the need to live by these priorities within standard expectations for decent business practice and fiscal solvency. Finally,

stakeholder theory, some accounts of professionalism, and some social expectations seek benefit to the community in which the provider organization operates. Thus, the yield of this distillation of the forgoing sources of guidance is a single list of priorities (not yet in a defended rank order):

- patients' health care services
- health professionals' expertise
- public health
- unmet health care needs
- advocacy for social policy reform
- relationships with clinical staff, management, employees and affiliated professionals
- organizational solvency/survival
- benefit to the community

The task of this section is now to rank the priorities and expand on how they can offer guidance.

1. The Priority of Health Care

All sources of guidance confirm the priority of health care. Business ethics, understood as best practices, encourages prioritization of mission over profit motives. The analogy between health care organizations and professional ethics demands that patient care be central. Law confirms this priority, and social policy, if confusing, does not deny this. We therefore identify patient's health as priority 1 for provider organizations' decision making. We do so in a two-step description. The first focuses on patient care priorities relative to other stakeholders' interests, and the second relative to the organization's fiscal well-being.

A. Priority of Patients' Health in Comparison With the Interests of Other Stakeholders

The stakeholder that appears to compete most strongly with individual patients for priority is the population of potential patients. The nature of the competition depends on how this population is defined. If the population is that of enrollees, then the competition becomes one of degree. Further, it is mostly a question of time before enrollees become patients themselves. This competition then is analogous to that for many other finite resources within a defined community. If population is considered broader than enrollees, the questions become more complex. This issue is addressed below in priority 3.

This priority provides no guidance regarding the relative priority of one patient group over another. Tradeoffs among patient groups' priorities are made still more difficult by the absence of any sort of detailed consensus in our society regarding how different types of patients' health care benefits are to be socially ranked. That is, holding that patients' health care in general is the most important end of provider organizations' actions leaves markedly unresolved many concrete circumstances that involve a tradeoff between various categories of patients'

health and/or various patient populations. Provider organizations often have little to guide them in ranking these, even when deeply committed to acting in accord with this priority. It is this void that makes it appear acceptable to provider organizations to enroll those who are wealthy and/or well and who will pose fewer problems of competition for resources.

If the population is defined generously to include nonenrollees, the competition becomes more difficult. Nonenrollees include the uninsured and underinsured, some of whom are acutely ill and costly to care for. Provision of unlimited care to nonenrollees would significantly limit the care available to patients and potential patients who are enrollees. However, unlimited care is not demanded by social policy, by law, or by business ethics. Even professional ethics recognizes limits in the provision of health care to any individual and to populations. The challenge is to define obligations (and limits) of provider organizations to nonenrolled members of their communities.

Other stakeholders include employees, suppliers, insurance groups, and (in for-profit entities) stockholders. At its simplest, the priority of patients' health means that any actions of a provider organization that benefit stakeholders other than patients must either be neutral, or yield a net gain in patients' health care. Neutrality does not mean that there is something ethically inappropriate in a provider organization's actions that advance the interests of stakeholders other than patients. Indeed, many of a provider organization's actions will be directed at favorably impacting the interests of other stakeholders in order to secure their services or other assistance in the meeting of the organization's goals, including above all the goal of patients' health. However, this priority permits such actions only if the result is that the health of patients is comparable or improved.

An additional factor is the requirement of all parties to refrain from coercing the others and to keep whatever contractual commitments they voluntarily undertake, an obligation frequently articulated in American society as respect for liberty. For this reason, the implications of this priority must be understood in such a way that they do not justify coercing stakeholders or failing to keep commitments already voluntarily made to such stakeholders, in the name of maximizing patients' health. The priority of individual patient's autonomy in relation to individual treatment decisions functions similarly. By analogous reasoning, those who claim that the interactions of organizations and their stakeholders are governed by other antecedent ethical principles, for example by principles of justice, might argue that particular organizational decisions must conform to these ethical principles in exactly the same way. While the importance of this priority is clear, it can be considered a framework within which patient care receives top priority. In other words, like population care when defined as enrollees, this requirement is more like a limit on the extent of the priority rather than a challenge to its primacy.

B. Priority of Patients' Health in Comparison to the Organization's Bottom Line and the Well-Being of Financial Stakeholders

It has been argued above that there is a clear requirement for all persons who work in health care in American society to give priority to the health of patients over most other considerations. In particular, it is a priority for organizational decision making that monetary gains for the organization, in whatever form, may not outweigh patients' health and similarly that the well-being of the organization's financial stakeholders, e.g., insurers and other payers or shareholders, may not outweigh patients' health. Of course, financial assets are absolutely necessary to run an organization. By the same token, for the organization to function fiscally, it must make agreements with various financial stakeholders. Thus, this standard cannot be interpreted as implying that weighing possible courses of action in terms of financial gain or loss for the organization, or in terms of the claims of financial stakeholders, is unethical. The point is rather that financial gain and the interests of financial stakeholders may not be sought for their own sakes in preference to the health of patients.

This priority entails that, even when the survival of the organization is at stake, monetary gains may not outweigh patients' health. If, for example, the circumstances were such that, in the decision makers' best, honest judgment, patients would likely be better served if the organization were to cease to exist by closing, then—if other things and other organizational obligations were equal (which would have to include organizational commitments already made to other stakeholders)—the decision to close would be the ethically appropriate path. This decision is faced, for instance, by the military when a front shifts from one area to another and care facilities are needed at the new front more than at the old. Thus, while this standard might seem to fly in the face of many principles of sound business management when seen only from the viewpoint of the business concerns of the organization that faces closure, it is not so absurd. A health care provider organization exists for a purpose, and that purpose is above all the health of patients. Although the existence of health care organizations is necessary for the achievement of this purpose, no single organization is essential to this purpose. If a particular organization's continued existence were actually not helpful to this purpose, then it is certainly a legitimate question whether there would be any good reason for its continued existence. The topic of organizational survival will be revisited below as priority 3E.

Admittedly, in practice, health care decision makers are unlikely to think it revolutionary to say that patients' health must come first for provider organizations. This standard is widely acknowledged and is arguably honored routinely in most decisions by provider organizations. Thus, the preamble of the Code of Ethics of the ACHE states that it is a fundamental objective of the health care management profession "to enhance overall quality of life, dignity and well-being of every individual needing

healthcare services” (ACHE, 1999). Moreover, patients’ health can be served in many ways, some of which are direct, others very indirect, and these different ways of serving patients’ health also fall within many different time frames. Far more often than not, provider organizations’ most difficult decisions involve choosing between one form of patient health and another, or between several forms, rather than simply between patients’ health and the monetary or survival interests of the organization or the interests of financial stakeholders.

2. The Priority of Professionals’ Expertise in Clinical Matters

Professional expertise has a special role as part of patients’ and society’s expectations simply because professionals are designated as the ones whose expertise must be consulted and taken as a guide on clinical matters, i.e., matters involving decisions about diagnoses, prognoses, and treatments. Obvious examples of organizational decisions involving such matters include decisions about whether the institution should offer certain surgical procedures, have certain departments, and so on. Thus, there is a powerful, continuing role for health professionals’ expertise in determining what counts as health for patients and therefore what sorts of interventions are beneficial to their health. Priority 2 is in a sense an extension of priority 1 and is procedural rather than value- or interest-oriented, since professionals are using their expertise for the sake of patient health care, both for individuals and for the population, however it is defined.

Importantly, nothing about priority 2 should be interpreted to imply the priority of any other interests of health care professionals in provider organizations’ decision making (see priority 3D below). Indeed, such interests may develop into conflicts that have to be addressed at the organizational level. Moreover, as we noted previously, the priority of professional expertise carries with it a reciprocal priority on the part of professionals to maintain standards of excellence. Professional excellence is necessary to deliver health care effectively and thus critical for organizational survival or success as a health care provider.

There are three ways in which respect for expertise should be given priority in provider organizations’ processes of decision making. First, and most obviously, organizational actions proposed to be beneficial for patients may not be judged beneficial independently of health professionals’ judgments on the matter. It is a matter of careful consideration, however, what sort of consultation with the health professions is a sufficient basis for determining professional judgment on such matters. In general, it is a consensus judgment of relevant health professionals collectively that is most authoritative in clinical matters; so organizational decision makers should seek to base their decisions on the collective expertise of relevant health care professionals. Since

much of the expertise available in provider organizations is presently focused on individual patient care, it is likely that, in the future, some increase in public health expertise will be sought.

A second implication of priority 2 concerns the relative health benefits of alternative courses of organizational action. Here, too, health professionals’ judgments must be considered if a provider organization’s decision-making process is to be ethically sound. However, the several health professions, and even some specialties within individual health professions, rank various aspects of patients’ health and of their health care needs differently and therefore may offer different rankings of the possible benefits of alternative forms of interventions. These differences in professional judgment about ranking relative health benefits further add to the complexity of provider organizations’ decisions that must determine which sorts of health care benefits for patients will be ranked ahead of which others.

A third implication of priority 2 concerns the impact of organizational decisions on patient care by health professionals. Many organizational decisions are very indirect in their impact on the day-in, day-out encounters between health care professionals and patients within their institutions. However, many decisions made at the organizational level have effects that reach those encounters and modify the impact of professionals’ patient care. Staffing decisions, for example, have significant impact on the availability of professional expertise in relation to its necessity for appropriate patient care. Organizational utilization standards, quality standards, and many common cost-containment efforts all affect, ordinarily by limiting, the reach of judgments by appropriate health professionals in directing the care of individual patients.

3. Six Additional Priorities

Priority 3 consists of six additional considerations that are necessary for ethical decision making by provider organizations. As genuine priorities for ethical decision making by provider organizations, they should be part of the deliberations of a provider organization in any decision in which they are relevant. The six considerations are gathered here under a single heading not because any of them are less important than the others, but because their ranking may vary depending on the social context and nature of the organization. Because these six additional considerations are variable in their ranking relative to one another, it follows that in any situation in which they cannot all be fully actualized, a provider organization may choose or be pushed by circumstances to focus on only one or some of them. While this lack of priority may be regrettable, it cannot be judged unethical except by considering the social context or circumstance in question.

A. Public Health

If one asks, “To whom are provider organizations committed to provide care?” the answer is not limited to patients currently in the organization’s beds, laboratories, or offices. One implication of this argument is that public health is an ethical priority for decision making by provider organizations, as part of priority 3. This is the focus of the present section. A second implication is that unmet health care needs are an ethical priority for provider organizations. That will be the subject of the next section (B). A third implication is that obligations to public health and unmet health needs are a societal as well as an organizational priority. More will be said about that obligation in section C.

Public health, in the sense of preventive health care to well populations, can refer in the context of provider organizations to enrollees or to nonenrollees. For this work, we will consider the former here and the latter under unmet health needs. Provision of public health occurs, for example, through perinatal programs, inoculation programs, and community nursing programs as well as educational and screening programs. Care for the health of patients cannot be readily understood to exclude public health measures. Therefore, provider organizations are obligated regularly to consider their capacity to assist and their potential contributions in addressing public health needs whenever expenditures of its resources are being decided upon. Further, it is readily apparent to provider organizations that it is in the interests of other priorities, including financial, to keep their enrollees as healthy as possible. It is therefore not usually problematic to place this priority at a reasonably high level.

Nonetheless, there appears to be greater immediate damage done by ignoring the care needs of an ill individual than by delaying preventive health programs for well individuals. For this reason, loss of public health programs may not be considered as egregious as loss of illness care capacities in any given provider organization. This assessment might not hold in regard to a policy affecting an entire region or nation. In this case, public health would need full consideration along with individual patient care. However, the present analysis of priorities is for individual provider organizations. As such, public health is a genuine but lesser priority for provider organizations than patient care. An organization that paid no attention to public health would be operating with a narrow and naïve understanding of health care, but it need not give as large a devotion of its services to public health programs as to patient care programs to behave ethically.

B. Unmet Health Care Needs

A second implication of the argument that begins the previous section is that unmet health care needs are an ethical priority for provider organizations. For this priority to differ from the previous one, it must refer to needs that exist in the nonenrolled population. As with the other parts of priority 3, the priority of unmet health care needs

does not imply that any individual or any provider organization is required to respond without limit to those with unmet needs. It implies rather that no one’s unmet health care needs may be a matter of indifference either to an individual health care professional or to a provider organization.

For this reason, decisions by a provider organization should include an evaluation of the impact of alternative courses of action not only on those whose health needs are served by it, but also on those whose needs will go unserved as a result. In a world of limited health care resources—whether these limits are natural in origin or are the consequence of social choices beyond the ability of health care professionals and other clinical staff and provider organizations to control—it is a fact of life that many decisions by provider organizations will leave some health care needs unmet. However, the reality that this is unavoidable in a particular society is no justification for indifference on the part of provider organizations. They must weigh their decisions carefully to minimize unmet health care needs as much as provident and effective use of their organizational resources permits.

Many theorists have argued that health care needs, or at least certain aspects of them, are basic needs and therefore have special moral significance that places them ahead of the other considerations in priority 3 and possibly higher in the model overall (Shue, 1996; Sterba, 1980; Daniels, 1985; Ozar, 1981, 1983). Notably, too, some classic and some more recent interpretations of the role of professionalism in society urge a higher priority to unmet needs. For example, some professional codes urge that all patients be treated equally regardless of ability to pay (Hippocratic Oath, Maimonides’ Prayer of the Physicians).

However, there is no consensus in the United States today that any specific categories of health care or health benefit have this kind of special moral significance (Buchanan, 1998). Even if a basic set of health care needs could be defined, the question remains for this work as to how much of the need ethically must be provided by any given health care organization, even assuming their contribution could be properly assessed. This determination is a societal one. Thus, while business ethics can identify commitment to health values as the core ideology of a provider organization, and the analogy with the health professional can note that health care for the uninsured is a high priority, society sets the possibilities for how this value can be realized and implemented programmatically.

In current social policy that provides such weak incentives or programmatic possibilities for health care coverage, the unmet needs are large. Under such circumstances, provider organizations often have to choose between solvency and contributing inadequate amounts of pro bono care. It would not be fair to judge provider organizations unethical for making the choice to survive,

not least because presumably survival is necessary to preserve what patient care is possible.

C. Advocacy for Social Policy Reform

We take seriously our arguments that organizations must be held accountable just as individuals must, and that provider organizations should be devoted to the moral mission of providing health care. If responding to unmet health needs is a priority for provider organizations, it follows then that the question of how well social policy permits devotion of provider organizations to addressing needs (and other core health values) is also a priority consideration in organizational decision making.

Given this, we want to extend the priority of unmet health needs to argue that provider organizations, like health care professionals, members of ACHE, and others, should be advocates for changes in social policy so that unmet health care needs can be adequately met in the society at large. We rank this as a priority because it is not possible for provider organizations to be fully devoted to their primary purpose, health care, given their limited resources and given that they operate in a society that constrains those purposes.

This priority reflects a growing consensus among health care organizations and professionals as well. For example, at the latest meeting of the Health Sector Assembly, a meeting attended by leaders from the professional, consumer, government, business, insurance, and academic sectors of health care, the consensus was that reducing the number of uninsured should be the first step in health care reform (AMA News and Information Report, 1999).

D. Relationships With Clinical Staff, Management, Employees, and Affiliated Professionals

Every organization has relationships of special ethical importance with its employees that are represented in all current formulations of normative stakeholder theory. This position of relative priority of employees among an organization's stakeholders derives not merely from a contract, but also from the complex and interdependent nature of the relationship that exists between an organization and its employees. Particularly when the work product is in the form of service to an organization's clients, it is impossible to separate work from worker. Consequently, the relationship between organization and employee must be understood in terms of shared effort and common goals and in terms of the ethical requirements that establishing and maintaining such a relationship imposes. Thus, employee relationships have an ethical priority among an organization's stakeholders because the ethics of reciprocity and shared effort make more powerful ethical demands on an organization than many of its other relationships, especially those in which only the ethical weight of a contract binds the parties together (Werhane, 1985).

Within provider organizations there is also a special kinship between the organization and the health care professionals and nonprofessional clinical staff who are the direct providers of health care to the organization's patients. This special kinship, while founded on the relationship of shared effort and common goals just referred to, is both strengthened and deepened by the specific shared commitment of the provider organization and the organization's clinical staff and other employees to serve the health of patients as priority 1. Because of this shared commitment about what is of the highest priority for both of them, the sense of kinship will likely be greater in this instance than in a provider organization's relationships with other stakeholders.

E. Organizational Solvency/Survival

It is important to note that organizational solvency/survival is something distinct from business success, at least if the latter is measured by the fiscal standards typically employed in the popular and business press. From an ethical perspective, business success consists in the maximization of the well-being of all of an organization's stakeholders, within the parameters of the ethical priorities for that particular organization.

This inclusion of organizational solvency/survival as one of the ethical considerations in priority 3 rather than higher in the ranking will surely find objections among organizational decision makers and those who study health care organizations, for it flies in the face of many commonplaces of ordinary business operations. The reasons for ranking it below priorities 1 and 2 have already been given in the sections on those priorities. In the minds of other critics, however, organizational solvency/survival should not be included among the ethical priorities of a health care provider organization at all. At the very most, such critics will argue, organizational solvency/survival may be mentioned in an account of ethical decision making by provider organizations only as necessary means to the provision of health care to patients and the achievement of the other priorities mentioned. However, it should not be accorded any genuine ethical priority in the decisions of provider organizations.

We argue that, while organizational fiscal well-being might not be a priority in other respects, organizational survival is important not only as a means to provide health care for patient populations, but as a genuine ethical priority because of the role of health care organizations as part of the community. When a provider organization fails or is shut down, loss of access to health care is often at stake. This is particularly evident in rural communities and in less affluent city neighborhoods. Moreover, the loss is not merely to those who require health care. There are losses in jobs and losses and disruptions to the community at many other levels as well.

These reasons do not depend upon acceptance of the ethical legitimacy of for-profit provider organizations, nor

do they resolve the question of such organizations' ethical legitimacy. It is still a matter of serious dispute whether the payment of reasonable dividends to investors should be viewed as simply an appropriate return to someone who has provided capital resources to the provider organization. In other words, it is a matter of dispute whether it is a violation of the priority of patients' health for American society to accept for-profit organizations as providers of health care. Those who accept the system in which provider organizations may operate for profit maintain that the distinction between nonprofit and for-profit provider organizations is to be understood as a difference in how capital financing is obtained and not a difference in the fundamental ethical commitments of these two kinds of organizations. We do not seek to resolve this dispute here, and nothing in this section argues for or against the ethical legitimacy of for-profit provider organizations.

F. Benefit to the Community

No organization can function effectively independently of numerous relationships with the community within which it is physically, culturally, and fiscally situated. Regarding the ethics of these relationships, the point was made earlier that there are antecedent obligations that require a provider organization to refrain from coercing others and to honor its voluntary contracts with the individuals and organizations with which it interacts, and there may be other antecedent ethical requirements on such relations as well. However, over and above these obligations, provider organizations have obligations of reciprocity and good-neighborliness that require them to evaluate alternative courses of action in terms of their impact on the people who support them, especially on the local community where they reside. They certainly have an obligation to avoid harming the communities that support them, and they may well have an obligation to repay these communities, especially the local community, in ways over and above providing quality health care, for the financial and social support they receive.

There are many ways that a provider organization benefits its various communities and fulfills this obligation. Educational programs and health screening programs are among the most obvious examples. Many organizations donate facilities, members of their staff to serve on public and charitable boards, and other assets, depending on the circumstances and the particular needs and customs of the community. However, in practice, even if the provider organization undertakes to make community service an element of the organization's mission and core values, there will be unavoidable limits to such contributions because there will be other pressing uses for these resources within the organization. Other considerations from priority 3 may thus ethically be chosen ahead of community benefit, provided that in every organizational decision the impact on the community is considered.

III. Organizational Decision Making and a Sample Case

The model described in Part II leaves a great deal underdetermined about provider organizations' dealing with stakeholders not considered in priorities 1, 2, and 3—e.g., suppliers, nonshareholder sources of capital, regulators, government bodies, and so on—as well as the interests not considered in priorities 1, 2, and 3, of the stakeholders mentioned in them. Subject only to two conditions, a provider organization may ethically advance any of these interests in an ad hoc fashion, establish any of these interests as elements of organizational mission and core ideology, and rank these stakeholders and these interests in any way that the organization's decision makers judge most consonant with the organization's mission and core ideology. The two conditions are (1) that the ethical considerations in priorities 1, 2, and 3 are not thereby violated or rendered impossible to achieve and (2) that doing so does not violate any of the antecedent moral requirements—e.g., to refrain from coercion and keep one's contracts—that bear on all relationships of all parties in the marketplace.²

It is also important to recall that an organization's alternative courses of action in a given situation can come out equal, even after the most careful reflection on the priorities in the model and on the other stakeholder interests involved. In such situations, if there is time to gather more data and the effort of doing so is likely to have significant value in terms of the outcomes of the courses of action, then a choice to gather that data and reevaluate the alternatives is reasonable. However, in some situations, even the most conscientious effort at careful deliberation yields the judgment that neither of the best alternatives can be judged to be better or worse than the other. When the best alternatives are conscientiously judged to be equal, the ethical course is to do one of them.

With these preliminary considerations in place, it is time to offer a fictional illustration of provider organization decision making guided by the ranked priorities in the model in Part II. Consider the following narrative of decision making by St. Eudora Health System.

St. Eudora's Hospital was founded in Twin Rivers by the Sisters of Charity in 1892, and the organization grew and prospered and served its community well. Like many Catholic hospitals, St. Eudora's also had a strong commitment to charity care, and its donors and staff had enthusiastically supported this commitment with dollars and volunteered hours for many years. The motto on the corporate seal was taken very seriously: "Care and Compassion for All."

During the 1990s, St. Eudora's administrators adapted to the rapidly changing financial environment, contracting with insurers and PPOs, establishing outreach programs and facilities to draw patients to the hospital, and tightening its belt

through intense utilization review and quality assurance programs. The hospital also succeeded in attracting most of its specialists into a unit of the hospital corporation, so that it was itself providing most of the specialty medical services that took place within its walls.

Last year, however, red lights started going off for one of St. Eudora's PPO agreements. A large number of the physicians who used the hospital, brought together in part by that common bond, had formed themselves into a PPO and begun to contract for covered lives in the Twin Rivers region. Unfortunately, like many physician-based PPOs in recent years, Metropolitan Physician Partners (MPP) proved to be undercapitalized. Last fall, because of the long delays for Medicare and Medicaid reimbursements, MPP had run out of cash to pay St. Eudora's for MPP's patients' use of hospital services and care by the St. Eudora specialists. The hospital accepted partial payment and gave the group an extension on the balance, and then did so again, hoping after each partial payment that MPP would be able to catch up and get stabilized again.

Certain units in the hospital felt the financial pressure of this action more than others—specifically the Free Clinic and the neonate service. Since the mid-1980s, donor support for the Free Clinic had fallen off markedly. It was now principally staffed by residents in the hospital's internal medicine residency program and by paid staff nurses, at much greater annual cost than before. Any persistent operational deficit would put the hospital's ability to maintain the same hours and services in the Free Clinic at serious risk. The neonate unit was fifteen years old. Its technology had been maintained, but the leadership of the neonate program had been saying for several years that a large influx of capital would be required very soon if it was not to become significantly outdated. It was getting more difficult to attract top candidates for its residencies and fellowships because other programs had more up-to-date facilities and more extensive resources for research. The hospital administration's plan had been to address this from this fiscal year's operational surplus. However, MPP's mounting deficit with the hospital cut significantly into the resources set aside for this purpose.

Terminating St. Eudora's contract with MPP would reduce hospital revenues significantly, but MPP's growing deficit could wipe out almost all of the hospital's projected operational surplus. Thus, terminating MPP would be the lesser of two fiscal losses for St. Eudora's. However, making this decision more complicated was the additional fact that more than 50% of the hospital's employees, professional and lay alike, were patients of the physicians in MPP. Terminating St. Eudora's contract

with MPP would leave these persons without access to hospital and specialist care at St. Eudora's.

Another possibility was to give MPP another extension. However, initial efforts by MPP's leaders had not identified a willing partner or sponsor who might bail them out. Thus, it was very possible that the effect of another extension would be that MPP's situation would continue to get worse unless some sort of angel donor appeared with capital assistance. What is the most ethical course of action for St. Eudora's administration to take?

Looking at the model in Part II, it seems clear that priority 2 does not help the decision makers at St. Eudora because the particular contribution of health professionals that it identifies as an ethical priority for provider organizations is their clinical expertise, and none of the alternatives is deficient or superior in this respect. Also, although a provider organization could establish a free clinic chiefly out of concern for public health (priority 3A) or benefit to the community (priority 3F), the Free Clinic at St. Eudora's exists because of the organization's long-standing commitment to respond to unmet health care needs (priority 3B). In addition, priority 3E, solvency/survival, does not appear to be significantly on the table because the issue at hand has to do with the disposition of an expected operating surplus. This priority would be relevant to the case if banks or other creditors—or stockholders in a for-profit provider organization—would likely take action having a significantly positive or negative impact on the hospital in response to how the hospital resolved this matter. For simplicity's sake, let us assume that this is not the case here. So priority 2 and priorities 3A, 3E, and 3F do not appear to offer significant guidance in ranking alternatives in the case at hand.

The hospital has already given MPP two extensions because, like many hospitals, it has priority 3D as an element of its mission and core ideology—trying to interact with all of its employees and, in this instance, its admitting physicians as partners in service to patients, with an emphasis on shared effort and common goals. Does the hospital's commitment to this priority now require it to offer a third extension to MPP? This might be the correct conclusion if the hospital's resources for the Free Clinic and/or the neonate unit were not in jeopardy because of MPP's shortfall. For the sake of this illustration, let us assume that, if MPP receives a third extension, the shortfall will likely be such that either the neonate unit will have to go without most of its renovations for one or possibly two years or the Free Clinic's hours will have to be cut by 20% for at least the next year and possibly two. It is now clear that priority 1, the health of patients, must be part of this decision-making process.

What complicates consideration of priority 1 in this case is that, when we are comparing the projected cutbacks in the Free Clinic with the projected cutbacks in the neonate unit, the comparison involves vastly different numbers of patients and very different kinds of health care. Sometimes the data in such comparisons permit

consensus about which cutback has greater impact on patients overall, and sometimes an organization's mission and core ideology will determine the priority. However, administrators at St. Eudora's might well conclude that, while a 20% cut in hours at the Free Clinic will produce more waiting for elective treatments, no life-threatening or other serious conditions will go untreated in timely fashion. Moreover, the neonate renovations, when completed, would not increase the number of infants that can be treated at one time and, even without the renovations, no infants requiring care are likely to die or be put at greatly increased risk of harm. That is, the administrators might conclude that both of these cutbacks would be unfortunate and would genuinely affect some aspects of patient health adversely, but that it is not possible to clearly rank one as having greater negative impact on patient health than the other.

There is also the plight of the MPP patients themselves. Let us suppose that it is doubtful that cancellation of MPP's contract by St. Eudora would mean that these persons lose their access to health care, though they would certainly be significantly inconvenienced in the interim and may well lose continuity of care. In that case, reflecting on this group of patients in terms of priority 1 does not point to a loss in the health of patient populations that clearly outweighs either the projected cutbacks for the Free Clinic or the delay in neonate renovation. Nevertheless, many of these patients, as indicated, are employees of St. Eudora's; and, as has been indicated, St. Eudora's has long held priority 3D to be an element of its mission and core ideology. Given both that the three uses of the operating surplus appear to be in equipoise and the general equality of the other considerations, St. Eudora's might rightly choose to act on priority 3D to give MPP one more extension and perhaps assist MPP in searching for a solution.

However, reduction of services in the Free Clinic will mean a lessening of St. Eudora's response to unmet needs. Does this mean that St. Eudora's would be acting unethically if it favored its employees in this instance and permitted its services in the Free Clinic to be lessened accordingly? In order to answer this question, we must pose two others. The first is whether St. Eudora does give priority to unmet needs. The second question is whether it is current social policy that has placed St. Eudora in the position of needing to lessen its services in the Free Clinic if it is to respond to its mission-based commitment to its employees. A provider organization that did not concern itself at all with unmet needs, but still had resources to give priority to stakeholders' interests not included in priority 1, 2, or 3 would be acting unethically according to the model in Part II. However, we know that St. Eudora does give some priority to unmet needs, and the proposed course of action is itself supported by priority 3D.

Regarding the second question, suppose that St. Eudora's decision makers conscientiously reason that the organization is faced with choosing between its employees and

unmet health care needs as a result of disproportionate demands being placed on it because there is no other health care organization willing or able to meet the unmet needs that exist and no broader social program adequate to meet them at all. Suppose, that is, that St. Eudora's is already doing its fair share in relation to unmet needs and, given its mission-based commitment, perhaps even more than that. In that case, the organization could legitimately conclude that the remaining burden of unmet needs is beyond its ethical responsibility.

In such a case, however, St. Eudora's would be obligated, we have argued in priority 3C, to actively advocate for relevant social change. When provider organizations are aware of unmet needs that they cannot meet given their other legitimate priorities, they are obligated to actively advocate for changes in the social system so that unmet health care needs can be adequately met in the society at large.

Suppose, then, that the final decision of the CEO is as follows: "When being faithful to our organization's mission is what is at stake, then preserving resources simply for the sake of future security is inappropriate. So we must be willing to employ resources that are not essential to meet our most basic obligations to our patients and to good quality care in order to serve the other priorities that our mission identifies as especially significant. The Free Clinic is itself a response to our mission-based commitment to unmet health care needs; but even with pulling back somewhat in services in the Free Clinic in the manner we think may be necessary, we will still be providing far more than this organization's fair share of that burden. What is really needed is major social change that will provide access to adequate health care for everyone; and for the sake of this we have lobbied and will continue to lobby in appropriate ways for social programs of that sort. In the present case, however, since so many of MPP's patients are our employees and their families, we will accept partial payment and give MPP an extension one more time; but we will do it only conditionally on their agreeing to let us assist them in finding a way to get their fiscal house in order."

Many readers may disagree with this solution, judging that other ethical considerations in the model in Part II should be weighed more heavily and therefore that a different course of action is more appropriate in the case. But what is important for present purposes is not whether there might be consensus among readers on how St. Eudora's ought to act. The important question is whether the model of ethical decision making offered in Part II and illustrated in this story of St. Eudora's offers an adequate account of standards of ethical decision making for provider organizations in American society. We believe that the eight ranked ethical considerations in Part II answer the question, "Which interests of which stakeholders should take ethical priority in the decisions of provider organizations in contemporary American society?"

IV. Conclusion

Americans think a lot about health care. Until very recently, however, the numerous decisions of health care organizations that significantly affect what health care is available, to be provided to whom, at what quality, and under what conditions, have remained almost invisible to the larger community, both professional and lay. The last decade has seen a great increase in awareness that health care organizations are significant players in the provision of health care and that the ethical standards that govern their decision making is deserving of the public's careful attention.

It is not the case that organizational decision makers have been functioning without ethical standards. However, these standards were mostly developed during a time when many health care organizations were spared the most demanding pressures of a competitive marketplace. They were able to grow and thrive without the sharp conflicts of constricting resources and market competition that have characterized the last decade. The pace of change during this last decade, however, has left little time to pause and reflect about the adequacy of organizational ethics standards that were created and implemented in more affluent times.

Active dialogue about organizational decision making in health care and the ethical standards that ought to guide it has become essential—for the organizational decision makers, for the community at large that is served by these organizations, and for health professionals. The concerns of the latter are focused almost exclusively on the needs of individual patients when organizational decisions, especially those with the widest impact, are necessarily formulated in terms of patient populations. It would have been possible for this essay to simply urge all parties to engage in such dialogue. Indeed, if the model in Part II found no supporters in any quarter, but stimulated intense dialogue among its critics, the essay will have achieved one important purpose. However, we have proposed the model in Part II out of a conviction that it does indeed articulate the current content of the criteria by which the American community judges the actions of provider organizations ethical or unethical. If this is true, then decision makers in provider health care organizations have available some concrete ethical guidance about how their organizations—and they themselves in their decision-making capacity—ought to act. In addition, as we have indicated, we believe each provider organization has a further obligation, hitherto largely unnoticed, to advocate for social change if it encounters unmet health care needs that it cannot address because its resources are limited and it is already doing its fair share in responding to unmet needs in other quarters.

There are several ways in which this essay could be developed, which relate in each instance to ways in which it leaves important matters underdetermined or fails to give specific directions to organizational decision makers. First, the model identifies patients' health as the highest priority without specifying how the concept of health is to be understood. Second, it offers no particular guidance about how tradeoffs between different patient populations are to be made when different kinds of health care or health benefit might be supported for the different populations but limited resources make it impossible to benefit all of them. However, the model does not offer more specific guidance to decision makers precisely because it aims to represent the current standards by which health care organizations are judged, and these standards themselves fail to give direction to decision makers in precisely these two ways. That is, the American community does not currently have a clear idea of what it means by health as the aim of health care, or a clear ranking of different kinds of health care or health benefit.

A third limitation is that the model has been developed specifically with provider health care organizations in mind. We chose to focus on provider health care organizations rather than health care organizations generally because the latter category includes organizations that differ from one another in important respects. It is reasonable to think that the American community is currently judging other kinds of health care organizations by similar ethical standards, and the model we offer here may be modified to apply accordingly. However, there is clearly much more work to be done to articulate appropriate ethical standards for other kinds of health care organizations.

Finally, it is worth asking, beyond the illustrative case provided, how our model should influence decision making. This question is both a personal challenge to decision makers in provider organizations and an organizational challenge. Each decision maker within such an organization must judge and choose how much to include standards like those articulated in Part II into his or her actions. For organizations, the model in Part II challenges them to consider how to embed these kinds of priorities as core values in their mission and throughout the organization's culture and decision-making processes. The possibility that these American standards are inadequate raises the question of the proper role of provider organizations in working for their improvement.

In either the individual's or the organization's case, obligations cannot be simply plugged in as variables into a moral equation or thoughtlessly applied in an algorithm. Careful ethical decision making takes reflection, practice, and dialogue, and it is learned best in company with strong core values and persons experienced in organizational ethical reflection. Our hope is that this essay will contribute to this process.

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- 1 We are speaking here normatively. There are a number of authors who have argued that professionals, including medical professionals, have failed to live up to their ethical obligations (see, e.g., Buchanan, 1996).
 - 2 Two additional general points about organizational decision making are worth noting here. First, all organizations have patterns of preferred practice, both procedural and substantive, that determine how numerous activities within the organization are routinely carried out. Some of these are the means by which the organization attends to the ethical considerations identified in the model and/or fulfills important elements of its organizational mission and core values. However, many are merely the habituated ways in which things get done. Habit is a powerful shaper of behavior and, wherever a habitual pattern of action is routine, there is a tendency to think that there must be an important reason for this pattern, precisely because it is routinely done. Consequently, decision makers at every level of an organization should be ready to challenge this tendency by inquiring whether there are significant ethical reasons for the pattern and, on the other hand, whether the pattern in any way places the ethical considerations in the model or other elements of organizational mission and core ideology at risk.

Second, any stakeholder who interacts with a provider organization knows—or should know—that patients' health is the highest priority for such an organization and that the other ethical considerations of the model are ethical priorities for provider organizations as well. As a consequence, all those who transact with provider organizations also unavoidably take account of these priorities, especially the impact on patients and the priority of professionals' expert judgments on clinical matters—in what they offer and what they ask for. That is, any other stakeholder who deals with a provider organization unavoidably accepts some limitation of the pursuit of personal or organizational self-interest in favor of the health of patients and the other priorities of provider organizations in these interactions. Consequently, if a provider organization's decision makers determine that a particular stakeholder is refusing to accord patients' health due priority in negotiations, for example, and is incorrigible in this stance, this would be a sound ethical reason for seeking an alternative partner for the matter at hand.

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